An Introduction to Montana's Kids Management Authorities (KMAs)

Background:

During the 2003 Legislative Session, the Legislature continued the work of Senate Bill 454, (Title 52, Chapter 2, Part 3), Montana's first multi-agency children's bill, in the form of Senate Bill 94. This statute charges the State of Montana, under the guidance of the Department of Public Health and Human Services (DPHHS), with the creation of a system of care. The system includes both an infrastructure and a comprehensive continuum of services for Montana's high-risk youth and their families, who are currently served by multiple agencies.

Senate Bill 94 also provided for the establishment of the Children's System of Care Planning Committee (SOC Committee), which coordinates the development of the State's system of care. This committee's membership is comprised of representatives from:

- State agencies which provide services to children;
- Parents
- Providers
- Native Americans; and
- Advocates.

The State, through the SOC Committee, provides leadership in the development of the system of care and Kids Management Authorities (KMAs) within Montana's communities.

This system will be designed through the efforts of the State and local communities. The KMA is the infrastructure upon which the State system of care will be built. The State is committed to this approach and has committed a limited amount of financial resources toward helping communities establish KMAs. The State, in partnership with the community, shares in the responsibility to ensure all KMA Community Team members are working together toward common goals and objectives.

The State also supports the development of KMAs on Montana's reservations. Because these organizations will be sensitive to the cultural structure of the respective reservations, this may result in a KMA that appears somewhat different than a non-reservation KMA. However, adherence to the basic principles and values of a system of care would still be foremost in their creation.

The KMA is built upon the values and principles of a system of care (articulated by Stroul and Friedman, *"Building Systems of Care - A Primer"*, 2002):

- *A system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.*

- *The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.*

- *The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they service.*

How it works:

The KMA is the infrastructure that supports a comprehensive and statewide system of care. The KMA has two primary functions, development of a continuum of care within their respective community, and case planning and coordination for individual youth with SED and their families. This system of care is child-focused and family-driven. It also provides wrap-around services to youth and their families within their community. Characteristics of the system include:

- A service design and delivery based upon the strengths of the youth, family, and community;
- An awareness of familial, cultural, racial, and ethnic differences;
- A focus on prevention/early intervention;
- An orientation toward outcome/results; and
- A funding mechanism that blends available resources.

The SOC Committee, together with community KMAs, identifies training needs, service gaps, funding, and other barriers to service delivery. Together, they implement responses to identified needs.

Funding:

In order for KMAs to be sustained over time, funding for operations must come from a variety of sources. Ideally, this funding should be flexible and not connected to any one category. The use of funds should be related to best practice principles and serve the needs of youth and their families.

Administrative functions related to KMAs will need assistance, including financial support. The DPHHS Health Resources Division's Children's Mental Health Bureau is committed to identifying funding to assist local KMAs.

Who KMAs help:

KMAs are geared primarily toward children with serious emotional disturbances who are at risk of, or currently residing in, out-of-home placement. These youths are typically served by many agencies.

The primary population also includes children under the age of six. The multiple treatment needs of these youths evolve and change over time.

Each KMA has the discretion to serve a secondary population of youth based on its ability to do so.

KMA Community Design Team Membership:

The KMA Community Team is a multi-agency community organization comprised of:

- Parents;
- Youth;
- State agencies serving children, including the DPHHS divisions of Child and Family Services, Developmental Disabilities, and Health Resources, as well as the Department of Corrections and Youth Court;
- Other programs that serve Montana's youth, including First Health;
- Tribal representatives;
- Providers; and
- Advocates.

KMA Community Team representatives will have the authority to make decisions about and allocate money for services to youth and their families. When the KMA is serving a Tribal community, Tribal representatives must have the opportunity to participate as full members in the KMA.

Because KMAs are local organizations, Tribal communities may wish to develop them respective to their communities as an option to joining off-reservation KMAs. To ensure coordination with Service Area Authority (SAA) activities, a representative of the regional SAA must have the opportunity to participate as a full member in the KMA. The KMA may add representatives of other community organizations and leaders as appropriate.

KMA Community Team Goals and Tasks:

Goal 1: Design, implement, and support a community-based system of care for youths and their families.

The KMA will accomplish this goal in two ways: As leaders within their communities, Community Team members identify gaps in the community system and develop needed resources for youth and their families. As the Youth

Coordination Team, the KMA plans, coordinates, and delivers services to individual youth and their families within communities.

Task 1: Build consensus among agencies in order to create a community focused on improving the lives of children and their families.

Task 2: Identify and/or create funding sources. This includes exploring various funding avenues, from fund raising to grant granting, as well as blending available monies in creative and flexible ways.

Task 3. Conduct broad-based community assessments; profile local gaps, strengths, and assets; and locate and/or establish needed resources within the community.

Task 4. Develop policies and procedures to ensure a unified and comprehensive delivery of services.

Task 5. Design data gathering methods, processes, and distribute data about all aspects of the needs of youth with serious emotional disturbance and their families to the State, community, providers, and the consumer.

Task 6. Track and monitor outcomes, collect data, and analyze information to support learning and decision-making.

Task 7. Serve as a gateway to the SED waiver established by the State.

Goal 2: Integrating wrap-around philosophy into service delivery.

Task 1. Develop mechanisms at the local level that ensure providers adhere to the basic principles of wrap-around philosophy as they implement plans developed by the Individual Care Coordination Team. This philosophy emphasizes that services will be delivered in full partnership with families, stressing the importance of outcomes and cultural competence.

Goal 3: Reduce the stigma surrounding serious emotional disturbances for individuals and their families.

Task 1. Serve as local educators regarding the comprehensive treatment process and needs of youth with serious mental illnesses and their families.

Task 2. Establish and implement a plan for identifying and training parents and youth to be active in policy-making functions of the KMA and the system of care. Provide training to parents and youth to serve as mentors to other parents, and formalize their roles as parent/youth advocates.

Goal 4: Partner with the State to provide information on the system's needs and development, participate in policy development, and educate legislators on the needs of youth with serious emotional disturbances and the impact on their families.

Task 1: Identify barriers to the delivery of services and communicate to the SOCs committee.

Task 2: Assist in adjusting policies, procedures, administrative rules, and protocols for the service system to accommodate integrated programming and a seamless continuum of care for youth.

Task 3. Serve as consultants/mentors by sharing ideas, experiences, and expertise with other communities.

KMA Individual Care Coordination Team Membership:

The Youth Care Coordination Team at a minimum consists of representatives from all State agencies that serve children. These representatives must have the authority to make fiscal decisions regarding services to youth and their families. Membership is specific to the youth and family being served. The parent is the key member and participant of this team, unless parental rights have been modified. The team leader for each meeting is established by the team.

In addition to these members, the youth's case manager, parole officer, and/or social worker are expected to participate in the planning, monitoring, and delivery of services developed by the Team.

Membership on the team may vary according to the needs of the child and his family, and may include:

- Caregivers;
- Mentors;
- Neighbors;
- Clinical consultants;
- Legal advocates;
- Agency representatives;
- School personnel;
- Tribal representatives;
- First Health; and
- Other individuals who best know the strengths and needs of the youth, family, and service system.

The team serves as the means by which all efforts and resources of the community and involved parties are organized and delivered in a comprehensive and unified way.

KMA Individual Care Coordination Team Goal/Tasks:

Goal: The Youth Coordination Team enhances access to an integrated, wrap-around system of services designed for the individual needs of children with serious emotional disturbances and their families.

Task 1: Meet as needed to coordinate service planning, delivery, and funding.

Task 2: Monitor service delivery for high-cost youth.

Operations:

The KMA's Community Team conducts its meetings on a regular basis at a place and time designated by its members. These meetings are focused on system issues and service continuum development. They are open to the public, except when specific cases are part of the discussion.

Youth Coordination Team meetings are limited to those individuals who need to be involved in the delivery of services or whose attendance has been requested by the youth and/or family. These meetings must adhere to HIPAA confidentiality requirements. The KMA will develop protocols for referrals based on individual community needs. Children may access the KMA by an agency, through a case manager, or by a member of the KMA team.

Under Montana law, KMAs meet the definition of a County Interdisciplinary Child Information Team and must abide by all related confidentiality standards. All agencies committed to being a part of the KMA must sign a Memorandum of Understanding and comply with HIPAA regulations.

The Benefits of a KMA:

The benefits of having a KMA for high-risk youth, their families, and their communities are many, including:

- Children and their families have a unified plan of care, which minimizes confusion;
- Children and their parents are the most significant members of the Youth Coordination Team;
- Children and their families experience fewer crises;
- Children receive the majority of their care in family-centered, community-based settings;
- Children are more competent at home and at school;
- Parents have a better support system; and
- Parents are more satisfied and empowered in the design and delivery of services for their children.

- Services and treatment is based on the strengths of the youth and family.

Its advantages for agencies include:

- Increased trust regarding the planning and delivery of services to youth and their families;
- Easier information sharing among agencies;
- Reduced paper work and administration;
- Unification in the care plan for children and families with multi-agency needs;
- Reduced pressure on partner agencies' budgets, allowing for the transfer of resources to more preventative and less costly services.

Its advantages for the community include:

- Ownership and accountability for children and their families' development in the community;
- Involvement in a creative process of providing services to youth and their families;
- An awareness and utilization of informal community supports for children and their families; and
- An increased sense of satisfaction regarding the accountability and effectiveness of services provided to youth and their families.

Challenges of a KMA:

While there are many benefits surrounding the establishment of KMAs, they are equally accompanied by challenges for participants, including:

- Resisting change, which may require altering the manner in which decisions are made;
- Sharing in the process of service planning;
- Changing the philosophy about how those decisions are made (family driven vs. agency driven), which could be met with some resistance;
- Accepting the values and philosophy of a KMA among agencies, which could be met with resistance;
- Evidence-based service development and delivery may be new challenges for the system of care;
- Funding source restrictions;
- Lack of appropriate services (such as family focused services and community based services); and
- Lack of provider networks.

To learn more:

Please see attached System of Care Map for local contact or contact Pete Surdock, Chief of the DPHHS Children's Mental Health Bureau, at (406) 444-1290, or e-mail him at psurdock@mt.gov.

GLOSSARY OF TERMS

SED	Serious Emotional Disturbance
SOC	Children's System of Care Planning Committee
KMA	Kid Management Authority
SAA	Service Area Authority
DPHHS	Department of Public Health and Human Services

Appendix B

(2) "Serious emotional disturbance (SED)" means with respect to a youth between the ages of 6 and 17 years that the youth meets requirements of (2)(a) and either (2)(b) or (2)(c).

(a) The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:

(i) childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90);

(ii) oppositional defiant disorder (313.81);

(iii) autistic disorder (299.00);

(iv) pervasive developmental disorder not otherwise specified (299.80);

(v) asperger's disorder (299.80);

(vi) separation anxiety disorder (309.21);

(vii) reactive attachment disorder of infancy or early childhood (313.89);

(viii) schizo affective disorder (295.70);

(ix) mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);

(x) obsessive-compulsive disorder (300.3);

(xi) dysthymic disorder (300.4);

(xii) cyclothymic disorder (301.13);

(xiii) generalized anxiety disorder (overanxious disorder) (300.02);

(xiv) post-traumatic stress disorder (chronic) (309.81);

(xv) dissociate identity disorder (300.14);

(xvi) sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89);

(xvii) anorexia nervosa (severe) (307.1);

(xviii) bulimia nervosa (severe) (307.51);

(xix) intermittent explosive disorder (312.34); and

(xx) attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above.

b) As a result of the youth's diagnosis determined in (2)(a) and for a period of at least 6 months, or for a predictable period over 6 months the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:

(i) has failed to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;

(ii) has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships;

(iii) has failed to demonstrate a developmentally appropriate range and expression of emotion or mood;

(iv) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings;

(v) has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or

(vi) has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

(c) In addition to mental health services, the youth demonstrates a need for specialized services from at least one of the following human service systems during the previous 6 months:

(i) education services, due to the diagnosis determined in (a), as evidenced by identification as a child with a disability as defined in 20-7-401(4), MCA with respect to which the youth is currently receiving special education services;

(ii) child protective services as evidenced by temporary investigative authority, or temporary or permanent legal custody;

(iii) the juvenile correctional system, due to the diagnosis determined in (2)(a), as evidenced by a youth court consent adjustment or consent decree or youth court adjudication; or

(iv) current alcohol/drug abuse or addiction services as evidenced by participation in treatment through a state-approved program or with a certified chemical dependency counselor.

(d) Serious emotional disturbance (SED) with respect to a youth under 6 years of age means the youth exhibits a severe behavioral abnormality that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least 6 months and obviously predictable to continue for a period of at least 6 months, as manifested by one or more of the following:

(i) atypical, disruptive or dangerous behavior which is aggressive or self-injurious;

(ii) atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;

(iii) atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual;

(iv) lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;

(v) indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child; or

(vi) inappropriate and extreme fearfulness or other distress which does not respond to comfort by care givers. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP , Sec. 53-6-101, MCA; NEW , 1999 MAR p. 1301, Eff. 7/1/99; TRANS , from SRS, 2000 MAR p. 481; AMD , 2001 MAR p. 27, Eff. 1/12/01; AMD , 2001 MAR p. 989, Eff. 6/8/01.)

52-2-301. State policy. The legislature declares that it is the policy of this state:

(1) to provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multi-agency service needs, to the extent that funds are available;
(2) to serve high-risk children with multi-agency service needs either in their homes or in the least restrictive and most appropriate setting for their needs in order to preserve the unity and welfare of the family, whenever possible, and to provide for their care and protection and mental, social, and physical development;
(3) to serve high-risk children with multiage service needs within their home, community, region, and state, whenever possible, and to use out-of-state providers as a last resort;
(4) to provide integrated services to high-risk children with multiage service needs;
(5) to contain costs and reduce the use of high-cost, highly restrictive, out-of-home placements;
(6) to increase the capacity of communities to serve high-risk children with multiage service needs in the least restrictive and most appropriate setting for their needs by promoting collaboration and cooperation among the agencies that provide services to children; and
(7) to prioritize available resources for meeting the essential needs of high-risk children with multiage service needs.

52-2-302. Definitions. The following definitions apply to this part:

(1) "High-risk child with multiage service needs"
(a) means a child under 18 years of age who is seriously emotionally disturbed, who is placed or who imminently may be placed in an out-of-home setting, and who has a need for collaboration from more than one state agency in order to address the child's needs.
(b) The term does not include a child incarcerated in a state youth correctional facility.

(2) "Least restrictive and most appropriate setting" means a setting in which a high-risk child with multiage service needs is served:
(a) within the child's family or community; or
(b) outside the child's family or community where the needed services are not available within the child's family or community and where the setting is determined to be the most appropriate alternative setting based on:
(i) the safety of the child and others;
(ii) ethnic and cultural norms;
(iii) preservation of the family;

(iv) services needed by the child and the family;
(v) the geographic proximity to the child's family and community if proximity is important to the child's treatment.

(3) "Provider" means an agency of state or local government, a person, or a program authorized to provide treatment or services to a high-risk child with multiage service needs who is suffering from mental, behavioral, or emotional disorders.

(4) "Services" has the meaning as defined in 52-2-202.

(5) "System of care" means an integrated service support system that:

(a) emphasizes the strengths of the child and the child's family;

(b) is comprehensive and individualized; and

(c) provides for:

(i) culturally competent and developmentally appropriate services in the least restrictive and most appropriate setting;

(ii) full involvement of families and providers as partners;

(iii) interagency collaboration; and

(iv) unified care and treatment planning at the individual child level.

52-2-303. Children's system of care planning committee -- membership -- administration.

(1) There is a children's system of care planning committee.

(2) The committee is composed of the following members:

(a) an appointee of the director of the department of public health and human services representing the mental health program;

(b) an appointee of the director of the department of public health and human services representing child protective services;

(c) an appointee of the director of the department of public health and human services representing the developmental disability program;

(d) an appointee of the director of the department of public health and human services representing the chemical dependency treatment program;

(e) other appointees considered appropriate by the director of the department of public health and human services who may be representatives of families of high-risk children with multi-agency service needs, service providers, or other interested persons or governmental agencies;

(f) an appointee of the superintendent of public instruction representing education;

(g) an appointee of the director of the department of corrections;

(h) an appointee of the youth justice council of the board of crime control; and

(i) an appointee of the supreme court representing the youth courts.

(3) The committee is attached to the department of public health and human services for administrative purposes only as provided in 2-15-121.

(4) Except as provided in this section, the committee must be administered in accordance with 2-15-122.

52-2-304. Committee duties. (1) The committee established in 52-2-303 shall, to the extent possible within existing resources:

(a) develop policies aimed at eliminating or reducing barriers to the implementation of a system of care;

(b) promote the development of an in-state quality array of core services in order to assist in returning high-risk children with multiage service needs from out-of-state placements, limiting and preventing the placement of high-risk children with multiage service needs out of state, and maintaining high-risk children with multiage service needs within the least restrictive and most appropriate setting;

(c) advise local agencies to ensure that the agencies comply with applicable statutes, administrative rules, and department policy in committing funds and resources for the implementation of unified plans of care for high-risk children with multiage service needs and in making any determination that a high-risk child with multiage service needs cannot be served by an in-state provider;

(d) encourage the development of local interagency teams with participation from

representatives from child serving agencies who are authorized to commit resources and make decisions on behalf of the agency represented;
(e) specify outcome indicators and measures to evaluate the effectiveness of the system of care; and
(f) develop mechanisms to elicit meaningful participation from parents, family members, and youth who are currently being served or who have been served in the children's system of care in the initiative.

(2) The committee shall coordinate responsibility for the development of a stable system of care for high-risk children with multiage service needs that may include, as appropriate within existing resources:
(a) pooling funding from federal, state, and local sources to maximize the most cost-effective use of funds to provide services in the least restrictive and most appropriate setting to high-risk children with multiage service needs;
(b) applying for federal waivers and grants to improve the delivery of integrated services to high-risk children with multiage service needs;
(c) providing for multiage data collection and for analysis relevant to the creation of an accurate profile of the state's high-risk children with multiage service needs in order to provide for the use of services based on client needs and outcomes and use of the analysis in the decision-making process;
(d) developing mechanisms for the pooling of human and fiscal resources; and
(e) providing training and technical assistance, as funds permit, at the local level regarding governance, development of a system of care, and delivery of integrated multiage children's services.

(3)
(a) In order to maximize integration and minimize duplication, the local interagency team, provided for in subsection (1)(d), may be facilitated in conjunction with an existing statutory team for providing youth services, including:
(i) a child protective team as provided for in 41-3-108;
(ii) a youth placement committee as provided for in 41-5-121 and 41-5-122;
(iii) a county interdisciplinary child information team or an auxiliary team as ` provided for in 52-2-211;
(iv) a foster care review committee as provided for in 41-3-115; and
(v) a local citizen review board as provided for in 41-3-1003.
(b) If the local interagency team decides to coordinate and consolidate statutory teams, it shall ensure that all state and federal rules, laws, and policies required of the individual statutory teams are fulfilled.

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